

MANAGING THE  
PERSON WITH  
INTELLECTUAL  
LOSS (DEMENTIA OR  
ALZHEIMER'S DISEASE)  
AT HOME



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## FOREWORD

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The problems faced by patients and family members of patients who have devastating loss of intellectual capacity or dementia can often be overwhelming. Frequently, answers to the simplest questions about how to continue daily activities or how to manage patients in the very fundamentals of home life become of overwhelming importance to the individuals in charge of care. There is no body of practical information generally available in the medical literature on such subjects and frequently physicians who are not in charge of caring for large numbers of patients or who have not gathered information about the subject, are unable to help patients or their families.

The group at the Burke Rehabilitation Center, Dementia Research Program, recognizing this need, has put together this manual on "Managing a Person With Intellectual Loss at Home." We have been fortunate to have contributions from a large number of physicians interested in this problem along with a number of skilled psychologists and social workers, and are especially fortunate to have had the husbands and wives of many of our patients help us with the practical aspects of how to manage a patient.

We believe that this manual will be of great use and hope that those who use it and who have suggestions for managing patients will communicate with us so that we can constantly enlarge this small encyclopedia of practical information for "Managing a Person With Intellectual Loss at Home."

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## INTRODUCTION

This manual is for people looking after an adult at home who is suffering from progressive memory loss and confusion. It is specifically addressed to the problem encountered by persons caring for individuals with Alzheimer's disease, a disorder characterized by degeneration of certain parts of the brain producing intellectual impairment. The condition was first identified by a German neurologist, Alois Alzheimer, in 1906.

Family members responsible for a patient with Alzheimer's disease often find themselves in a situation that is as bewildering to them as the disease is to the patient—one they may not understand and may not feel equipped to deal with, at least at the outset. There are questions about how to deal with the small problems which crop up in the course of a day, what is happening to the patient, whether one is doing the correct things, what is right for the person in charge and the rest of the family, and what to expect in the future. As we move through new stages in life, we frequently turn to books, courses or experienced individuals to help us with the unknown. Coping with a patient with Alzheimer's disease also requires some special learning.

Many of the suggestions offered here have come from people who have solved their problems through trial and error. Other suggestions have resulted from the experiences of staff in day treatment and similar group programs designed to aid the patient with Alzheimer's disease. Advice has been sought from neurologists and psychiatrists with long experience in treating Alzheimer's disease. None are hard and fast rules. Some may be helpful, some not. Individual circumstances vary considerably. Once there is an understanding of what the personal problems of the patient are, and what the illness means in terms of impaired memory and orientation, it is important to remember that improvisation and practicality can be most helpful.

At the present time there is no known way to recover mental function lost due to Alzheimer's disease. The problem remains with the family to manage the situation as well as possible as long as it is manageable, and to seek the help of others when that becomes necessary.

# ACKNOWLEDGEMENTS

Published by The Burke Rehabilitation Center Auxiliary  
785 Mamaroneck Avenue  
White Plains, New York 10605

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Executive Medical Director

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## BACKGROUND

There are numerous causes for memory problems in adults. Among these are multiple strokes and heart attacks, parkinsonism, arteriosclerosis, psychiatric illness, abnormal thyroid function, alcoholism and drug abuse, nutritional deficiencies, and excessive medication. In some cases, forgetfulness and confusion can be reversed by treatment. Often the condition is associated with aging. However, Alzheimer's disease can begin in middle age. The cause is not known, but it is known that the condition results from degeneration of nerve cells in the cerebral cortex—the outer layer of the brain.

The word "dementia" refers to progressive intellectual decline and memory loss. Because there are a variety of factors which can produce these symptoms, it is imperative that the afflicted individual undergo a thorough neurological, physical, and psychiatric examination, including computerized tomographic x-rays of the head (CT scan). Through these examinations the precise cause of the mental decline often can be determined. Alzheimer's disease is a "diagnosis of exclusion." The label should not be applied loosely without complete evaluation.

The course of Alzheimer's disease has been divided into four phases. We can all recognize some of these symptoms in ourselves from time to time, but they are generally the result of fatigue, depression, frustration, illness or fever, and we recover from them quickly. The person with Alzheimer's disease can be described as follows:

### First Phase:

Often this phase is insidious, and no one is quite sure anything is wrong.

Less spontaneous, less sparkle  
Slower. Less energy, less drive, less initiative  
Less discriminating  
Loss of words  
Slower to learn, slower to react  
Readily made angry  
Seeks and prefers the familiar, shuns the unfamiliar

### Second Phase:

While still functioning in many ways the patient may need supervision in specialized activities such as balancing a checkbook.

Much slower in speech and understanding  
Great difficulty in making decisions and plans  
Inability to calculate  
Increasingly self-absorbed  
Insensitive to feelings of others  
Avoids situations that may lead to failure  
Loses thread of story

### Third Phase:

Now the patient is obviously disabled.

Markedly changed behavior  
Uncertain as to how he or she is expected to act  
Directions need to be repeated  
Memory of recent past poor or failing  
Memory of distant past astonishingly clear  
Loses orientation to time and place  
Invents words  
Misidentifies people  
Lethargic  
Little warmth

### Fourth Phase:

In this phase, help is needed with simple activities of daily living.

Apathetic  
Poor remote or recent memory  
Cannot find the way around at all  
Incontinent  
Perseveration of phrases and syllables  
No recognition of individuals

Progression of mental and physical deterioration may be rapid or may proceed slowly over a number of years.

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## WHAT YOU CAN DO TO MANAGE THE PATIENT AT HOME

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It has often been observed that the individual with Alzheimer's disease is aware of the memory loss long before family, friends, and co-workers notice it. He or she will attempt to cover up by relying on written reminders on slips of paper, by cueing others to mention their names first, by changing the subject, or by avoiding certain conversations and social situations. Eventually, the memory loss becomes obvious to family and associates. One striking example is that of the person who has been noted for remembering faces, names, and places, but now is unable to recall the name of a close friend. Another example is that of an individual who repeatedly gives you the same information.

For the person who suffers this gradual memory loss there is a devastating loss of a sense of personal dignity and a complete lack of confidence. Confusion and disorientation result in fear, anxiety, irritability, restlessness, and sleeplessness. These problems need to be handled with patience and understanding by family members. Remember that the personality of the individual has not changed essentially. If the person has been somewhat passive and accepting before the onset of the disease, the same pattern will probably prevail. If the style has been independent and self-determined, he or she will continue to behave in the same manner, despite the limitations of the disease. Because the degree of functional dependence will keep pace with the progression of the disease, it is necessary to determine, continually, how much assistance—human or mechanical—is needed to aid and protect the patient.

Recognizing all these factors in any given situation, the appropriate attitude is one of forbearance and reassurance. Matter-of-factness, repetition, consistency and good humor will help to achieve a calm atmosphere in the home. The tasks of daily life can be accomplished without unnecessarily upsetting and confusing the patient. The quality or tone of voice one uses is important. A quiet voice, without undue emphasis, is preferable. So are touching and patting, reassuring and praising, indicating affection, trust and protection. Appropriate humor is always helpful. The basic approach is to try to simplify routines and reduce available choices in order to allay feelings of anxiety and frustration for both the patient and the family.

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## AIDS TO MEMORY (REALITY ORIENTATION)

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You can help to make the most of the patient's residual abilities by keeping avenues of communication open and by giving verbal cues to help keep him oriented. A calmer, more normal atmosphere can be achieved at home if you can maintain a consistent routine. Name events on the day's schedule, repeat the names of individuals aloud, including your own. One spouse begins each day by saying something like, "What a beautiful sunny Monday morning. I'm your wife, Mary. Now I'm going to fix your breakfast. You'll have orange juice, cereal, toast with jam, and coffee. After that we'll call our daughter, Susan, on the telephone."

Some useful memory aids include a large prominent clock, a large wristwatch, and a calendar with the days marked to help keep track of time. A list of the day's activities in the order of their occurrence (including mealtimes and menus) can be posted on a bulletin board or written in large letters on a sheet of paper.

Repeat instructions frequently or write them down in proper order. Books, magazines, and other implements of daily living should be kept in the same place all the time. Many people enjoy looking at family photographs. The album or a box of pictures can be kept near his or her favorite chair.

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## BATHING AND GROOMING

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Safety, simplicity, and self-esteem are the prime considerations in bathing and grooming activities. Self-esteem accrues to the person who is clean, who has had his daily shave, whose hair is neatly combed, whose clothes are pressed and mended and nicely matched for style and color.

Some individuals may resist bathing or changing to clean clothes. It may be necessary to remind your relative often why bathing and changing are necessary and then make the task seem easy. If the patient consistently balks, ask your physician to write on a prescription pad "Bath—2 or 3 times weekly". By having this prescription on hand it may be easier to persuade someone to bathe when he or she may be resistive.

Perhaps bathing can be managed alone if the implements are arranged in the order in which they should be used. Only one task should be attempted at one time. Soap, wash cloth and towel can be laid out in sequence. It is wise to check the temperature of the bath or shower water, the depth of water in the tub, and finally to check to see if the water has been turned off. Tub bathing should only be attempted if the individual is agile enough to get in and out of the tub independently.

The person in charge should not be occupied in another part of the house while the patient is bathing or shaving. The lock on the bathroom door should be removed or deactivated. When razors or hair dryers are used someone should be in attendance. Instructions as to how to go about a task can be repeated. The installation of handrails, tub mats, and other assistive devices may be advisable as safety precautions. Use plastic instead of glass containers.

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## BED WETTING/ INCONTINENCE

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Bed wetting, and eventually incontinence, are common problems among the population with Alzheimer's disease. Initially, there may be only an occasional accident. The capacity to respond to the signal or to remember where urine or feces are to be deposited may be impaired and thus requires that toileting be supervised.

To minimize the difficulties, the family can establish a toileting program by reminding the person to go to the bathroom every two hours, with special reminders on rising in the morning, after meals, and before bedtime. If the individual suddenly becomes restless, it may be a signal which you can interpret for the patient who is unable to remember what is required.

Special clothing which utilizes disposable pads has been designed for the incontinent adult and can be obtained from surgical supply houses or some drug stores. Protective bedding and disposable bed pads are also widely available.

Intake of fluids can be restricted for some hours before bedtime. A commode or urinal bottle may be placed near the bed. If nighttime incontinence becomes severe, you might consult your physician about using an external catheter and collecting bag at night.

Bowel movements can be regulated through the use of a Fleet® enema or suppositories. Fecal incontinence (also occasional) may occur later. Remember that dribbling stool sometimes results from too much stool in the bowel (fecal impaction). Your doctor can help you to recognize that problem and remove the cause.

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## CHILDREN

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Small children, with their happy natures and unembarrassed manners, are a joy for the patient with Alzheimer's disease and should not be discouraged from visiting and playing with the individual. Teen-agers, on the other hand, may be extremely embarrassed to introduce or be seen with a mother, father, or other relative who does not behave normally. Each member of the family should have clear understanding of the disease and its effect on the patient. Young people should be encouraged to bring their friends home after explaining what the problem of the patient is and how to handle it. Adolescents respond generously when they can better understand their own feelings and are sure how to conduct themselves. You can explain that the patient is sick and that Alzheimer's disease is not so rare.

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## COMPREHENSION

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It is difficult to lower one's expectations of a person with whom one has lived closely for many years, but it becomes necessary in dealing with Alzheimer's disease. To avoid conflict, don't try to explain or make someone do something when he or she can no longer understand what you are saying. Instead, try to help that person. If you want to get an idea across, begin by showing how the task can be accomplished and then help the individual to follow your instructions. You can reinforce the thought by using pictures or gestures—e.g., by referring to the sense of smell (as with flowers) or the sense of taste. Whenever possible you can inject the situation with humor. Speak slowly, distinctly, and softly. Repeat the idea. Phrase your thoughts in one or two different ways in a calm, reassuring manner. Always maintain eye contact to help keep his or her attention.

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## CONSTIPATION

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If you think the patient is constipated, be aware that daily bowel movements are not essential. One can be comfortable with a bowel movement every two or three days. Your doctor can advise you about the use of agents which add bulk to the stool or soften the stool, as well as about the safe use of laxatives. Chronic constipation should be reported to the physician.

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## DEPRESSION

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Members of the family will undergo times of depression and anger when living with a relative who suffers memory loss and intellectual decline. It is to be expected. Don't let depression become severe. Counseling—either individually or in groups—will help you. It can be obtained from a private therapist or through a community agency.

Depression in the patient may have been diagnosed in the multidisciplinary examination mentioned earlier, and provisions for treatment made at that time. If later on, you become concerned that depression has recurred, you should seek advice from the patient's physician.



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## DRESSING

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There are no recommended modes of dress. Whatever is easy, appropriate, and familiar is best. Reduce choices in color and style, and in matching tops and bottoms. Clothing that is seldom worn should be removed from the closet so the patient won't be forced to choose from a large selection. Simple garments with front closings, large zipper pulls, and few buttons are easiest to put on. Cardigans are better than slipover sweaters. Because of accidents caused by incontinence or spilled food, you may find it better to use only wash and wear clothing.

When the individual is dressing, lay out the underwear first, then the outer clothes, then the shoes and stockings. You can help by showing how to put one sock on and let him do the other. It's best to stay in the room and supervise the dressing, and at the same time remove the clothes your relative has just taken off. If he or she wants to wear the same thing every day, don't argue.

While dressing, there is an opportunity to praise the individual by commenting on how handsome or beautiful the person is. It has been observed that those who are well dressed seem more comfortable, while those who are sloppy seem to reflect the state of their clothing in their behavior.

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## DRIVING A CAR

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Driving an automobile can produce stress for a well person. For the patient, driving has the potential for increasing anxiety and irritability. For some it is a relief to be rid of the responsibility. Others may fiercely resist the idea of giving it up. To avoid another source of conflict between the patient and the family, ask the physician to inform the patient that he or she can no longer drive.

Is it safe? Can the driver remember to brake, to signal a turn, to switch on the headlights? Can the driver remember where he is going or how to return? Whether or not someone should be driving a car depends on his or her judgment, reaction time, and spatial perceptions. In making this decision for another, you should be mindful of the safety of others and the legal implications involved.

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## EXERCISE

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Exercise is important for good health for everyone. For the person with Alzheimer's disease, walking not only provides excellent exercise, but also seems to relieve tension. Using a rocking chair also seems to lessen tension and therefore is a good indoor exercise. Dancing, if the patient enjoys it, is also helpful. In addition, the music seems to have a beneficial effect. Movement of any kind is good. Sweeping the floor or patio can be a form of exercise.

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## GOING OUT ALONE

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Safety is one consideration when you are deciding whether or not your relative should be permitted to go out alone. You also need to have confidence that he or she can reach the intended destination and find the way back.

Wandering is a well-known habit of the person with Alzheimer's disease. If your relative tends to wander, you can place an identification tab around the neck or wrist which gives the person's name, address, and telephone number. Then, if he becomes lost, it will be possible for those he meets to help him return home.

Restless patients may find their way out of the house despite locked doors during the day or at night. One way to avoid this is to move the door lock to the bottom of the door where the person may not think to look for it. Installation of a dead bolt lock is another preventive measure.

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## LEGAL AND FINANCIAL MATTERS

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It is important to consult a lawyer at the outset in order to assure legal protection for the patient and family members. Any will the patient has made should be located, the value and number of securities should be determined, and funds transferred out of the patient's name with his or her cooperation. It is a painful fact that some patients become unduly suspicious, yet it is seldom wise to act with secrecy.

Adjustments should be made to holdings which require his or her signature alone or which require two signatures. You may need to acquire a power of attorney.

Insurance policies and pensions should be investigated. Check to see if the person is eligible for disability benefits, veterans' benefits, or Supplemental Social Security. You should ascertain what outstanding debts there are and what business commitments. Finally, the responsible family member should arrange for care of the patient should he or she predecease the patient.

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## LEISURE ACTIVITIES

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Complex games and crafts are not useful, but keep in mind that adults don't like to be treated as children. In group settings, it has been found that patients enjoy simple games like shuffleboard which they are able to play and which they regard as an adult game. Whatever is attempted, remember that the patient tends to have a short attention span—no more than 30 minutes, often less—and has little creative capacity or sense of humor. Two very rewarding activities are gardening and music. Music particularly may help recall childhood events or past pleasures. If the individual is bi-lingual, music and songs which involve the first language are wonderful.

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## LOSING THINGS

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It is common for the individual with Alzheimer's disease to lose things or hide things. You cannot expect anything to be returned to its customary place. The family should remember to keep track of eyeglasses, dentures, hearing aids, money, keys. Personal items can be labeled for easier recognition. Family treasures and all things of value should be kept out of sight so they cannot be misplaced.

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## MEALTIME

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There are no special nutritional requirements. Meals of normal nutritional value should be offered, and menus kept familiar. At times, the patient may wish to eat ice cream or some other food several times each day. Such excesses are no more harmful than to the normal person, but a persistent craving for sweets or other snack foods can lead to excessive weight gain. This kind of behavior can be allowed to a limit where it does not interfere with accepted nutritional standards or with the dietary restrictions for diabetes, hypertension, etc. However, it is better to allow a patient to eat what he wants rather than not to eat at all.

Announcing ahead of time what the next meal is to be (breakfast, lunch, snack, dinner) and what time it will be served, helps to reduce disorientation. At the table, present one course at a time. It may be confusing to see the entree, beverage, salad, dessert, and all the utensils arrayed around the place setting. Serve one dish at a time, and when it is finished, offer the next.

You will find it necessary to become increasingly tolerant of poor table manners. When there is a tendency to forget utensils and to eat with the hands, finger foods, such as sandwiches, are a good idea. If the person begins to stuff too much food in the mouth, you must remind him to swallow. Cutting foods into small pieces helps to prevent choking.

Conversation during mealtime will help create a social atmosphere. The patient should be given as many opportunities to join in the discussion as feasible.

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## MEDICAL CARE

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After the patient has undergone a thorough neurological, physical, and psychological examination and the diagnosis of Alzheimer's disease has been confirmed, the family should seek care for the patient by a physician who is aware of the effects of the illness on both the patient and family. This type of patient is frequently unable to express complaints about discomfort, so the family needs to be alert for signs of injury or illness. Close collaboration between the family and the doctor is important in the prescription of medications and monitoring any adverse effects.

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## MEDICATIONS

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A variety of pharmacological agents can be prescribed for elderly people to help combat the illness that may affect them at one time. These can be medications for heart disease, diabetes, arthritis, hypertension, parkinsonism, and others. It has been observed that combinations of drugs can have an intoxicating effect on the fragile central nervous system of the older person. There may be adverse reactions to sedatives, analgesics, tranquilizers, and anti-depressants. On the other hand, tranquilizers may help alleviate the distress of the restless, irritable patient who is disrupting the household. In deciding, with the physician, whether or not to give a tranquilizer, it is necessary to weigh the value of its use to stabilize the home atmosphere against the possible negative effects for the individual.

It may be that more than one physician has been consulted, and that each may prescribe medications for a specific condition without being aware that the patient is taking other drugs. A family member can be responsible for keeping all attending physicians informed of the different medications. Ideally, a single physician should prescribe and coordinate all medications and monitor the patient's reactions.

It is unwise to trust a forgetful person with the responsibility for administering his or her own drugs. A family member should dispense the medications at the proper time in the proper dose, and should remain with the patient until the drug has been consumed. Medications should not be accessible to the patient. Again, it helps to repeat to the patient what the medication is and why it is being taken when the dose is given.

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## NIGHTTIME SUPERVISION

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Some patients sleep during the day and are awake and restless at night. Nocturnal wandering accompanied by confusion and blurred images are both disruptive and dangerous. Some medication may need to be prescribed to insure sleeping at night.

If there is restlessness at night you can try to convey feelings of comfort and security with an embrace, a back rub, soothing words. Drawn window shades will keep the room dark during seasons of early morning light.

Precautions can include closing bedroom doors whenever feasible, and keeping a night light burning. If the person is likely to try to leave the home, a bell affixed to the exit door will alert the family when the door is opened. As mentioned earlier, the lock on exits can be moved to the bottom of the door where the person is less likely to find it.

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## RESPITE FOR THE FAMILY

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It can be rewarding to ask for help for a few hours regularly each week or for an occasional weekend. Many families have found that relatives or close friends are willing to share the burdens of care. In the best interest of both the substitute caretaker and the patient, helpers should be aware of the basic rules of patience, forbearance, reassurance, repetition, and good humor.

When you leave for a few hours or a few days, you will want to provide a written message for the patient to carry, stating where you have gone and when you will return. You should do this if you leave the person in another setting while you are gone. Patients can become fearful that you will not return if they cannot remember your plans. If at all possible establish regularly scheduled times to be away so that your absence becomes part of a routine.

Occasionally, the patient may balk at going out or doing something that is important. If time is significant, a neighbor who is familiar may be called upon to encourage compliance.

An adult day care program geared to the adult with memory loss is another source of help for the family. Such programs offer a period of time one or two days per week during which the patient can be left in the care of others. You yourself can seek out self-help groups or a local family counseling agency. There is comfort in talking with others who understand or share the same problems.

How long should the family accept the responsibility of care? Mental decline can lead to a lack of awareness of the immediate environment and a loss of voluntary and involuntary motor functions. The professional who is asked what to do may counsel the family in this way. With advancing disease there may come a time when people are less important to the patient than the service which they give. It may no longer matter who gives the service as long as it is done, and there is no true recognition or special reaction to a loved one. In the end, a patient may prefer to lie in bed undisturbed by people even though he may need to be turned, bathed, and otherwise cared for. The physical needs and their satisfaction are nearly the only things that matter.

When the patient's condition begins to reach these levels, then one must ask these questions: Is the situation manageable? Is he or she safe in the home environment? Is the family physically and emotionally able to care for his needs and protect him? Is the patient able to function independently in the most basic ways? Is the cost of 24 hour supervision by paid personnel greater or less than the financial and human cost of the trauma (for both the family and patient) of institutional care? When the situation appears to be unmanageable, consultations with family members, physician, a family counseling agency and clergy are recommended.

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## SAFETY

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Boiling water, hot fat, stove burners, matches, cigarette lighters, firearms all hold potential for danger, of which the family should be continually aware. Some patients will drink any liquid they see. Cleaning fluids, cooking ingredients, paint supplies should be kept out of the way.

Problems with mobility may become evident, necessitating an increased awareness of extension cords, footstools, scatter rugs, and similar objects which can cause a fall. Keep household furnishings in the same place all the time in an effort to avoid accidents as well as lessen confusion.

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## SEXUAL BEHAVIOR

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As the patient becomes less competent in other areas, his or her sexual performance may be affected. If the spouse feels sexually stimulated, he or she may need to take the initiative by taking a larger role in the act. Aberrant sexual behavior, such as publicly masturbating or touching others, should be gently but firmly discouraged.

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## SMOKING AND DRINKING

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If either smoking or drinking has been a habit with a patient, it may be just as well to let the practice continue, but unwise to encourage it. Smoking should be supervised because of the danger of burns or fires. If you go out and leave the patient alone, remove the cigarettes and matches. Do the same if the person tends to roam the house at night.

An occasional drink before dinner is permissible, but since the mixture of alcohol and any drugs the patient may be taking can have an adverse effect, drinking should be strictly limited. Because the individual may not be able to judge or measure the amount of alcohol to be added to a drink, it is wise to mix the cocktail and serve it. Bottles of alcohol should be kept out of sight.

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## SOCIAL SITUATIONS

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Families sometimes think that a vacation trip will benefit the Alzheimer's person, that he or she will relax and come back better than ever. Such trips are usually unwise. A trip to an unknown place, surrounded by strangers, sleeping and eating in unfamiliar rooms only tends to upset the patient. There is much more comfort and ease at home where people are familiar, where the location of the bathroom is known, where one is not required to order from a menu, where the magazines and television are always in the same place.

However, some success has been reported by families who have rented apartments or houses in vacation areas. They say they have been able to simulate a home-like setting and keep daily routines simple and familiar.

If the caring member of the family needs a vacation, it may be desirable to leave the patient at home in a familiar place with a familiar companion. Provide a reassuring note stating where you are going and when you will return.

At home you can encourage friends and neighbors to visit if they are aware of the situation and seem able to handle it. One or two people are sufficient, however, and the patient should be told about the visit beforehand. Their names can be repeated after they arrive. Slight acquaintances, who may be embarrassed, should not be encouraged to visit.

If eating out is important it can be continued under certain conditions. Fast food restaurants may be a good solution to dining out. When the patient and family are with friends, let friends help in the selection of place, maintaining good manners, etc. Most friends will cooperate when they see this as "respite" for the family.

At social gatherings, conversation can revolve around reminiscences of the patient who may be able to talk about past events which are clearly remembered. If the thread of what is being said is lost, or a word can't be remembered, you can supply a gentle cue, just as you do at home every day. Sometimes the patient can be primed beforehand with reminders of suitable stories for the occasion. Remember, too, that many are happy to be only observers in social situations.

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## SPEECH

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Do not discourage rambling, incoherent speech, or your relative may become more and more reluctant to talk. Nod and smile while he or she is talking, and at the same time try to get the sense of the thought. Because memory of past events can be very clear, the individual may sometimes be talking about something that happened many years ago, and has suddenly interjected the thought into the current conversation. Cue the person who is fumbling for a word.

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## TELEPHONE

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If you can go out and leave the patient alone, you may want to disconnect the telephone or attach an automatic answering device to record messages while you are gone. If, when alone, the patient answers the telephone, he or she may not understand the call, may not know who is calling, and may upset the caller. In the end, you may never get the message anyhow. It's also possible that he may initiate a call and then forget why he's speaking on the telephone. A simple device to switch off the phone can be obtained at most telephone stores.

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## FINALLY

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The ideas assembled here are offered with the hope that they may prove helpful in themselves, or serve to point the way to individual solutions to specific problems. It is also true that many family members, who are caring for the patient with Alzheimer's disease, have found comfort and help in talking with others who are concerned with the same problems, either personally or professionally. Some possible sources of help and information are listed in the next section.

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## SOURCES OF HELP IN THE COMMUNITY

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Alzheimer's Society (and similar self-help groups)  
Adult Day Care Programs  
County Health Department, Public Health Nursing Office  
County Mental Health Department  
County Office Of The Aging  
Clergy  
Legal Aid Society  
Social Service Agencies  
-Catholic Charities  
-Family Service Bureau  
-Jewish Family Service  
-Mental Health Association  
-Protestant Welfare Agency  
Specialized Neurological Clinics  
Visiting Nurse Service

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\*Ask for list of publications appropriate to the elderly brain failed at home. Send to Disabled Living Foundation, Information Services For Disabled Persons and their Families, 346 Kensington High Street West, London, England 14-8NS

